Designs in Dentistry

Confidential Patient & Responsible Party Information

Patient Name: _____ **Preferred Name** _____ **M / F**
Last First M.I

Birth Date:_____ Patient's Social Security #: _____

Address: _____
Street City State/Zip Code

Home phone: (___)_____ Cell phone: (___)_____ Other: (___)_____ E-mail_____

Emergency contact, outside immediate household: _____ Phone: (_____)_____

_____ Relationship: _____
Street City State/Zip

If patient is a minor or dependent, name of parent/guardian:_____
Last First M.I. Relationship

Other family members who are patients of Designs in Dentistry_____

Employment Information

Responsible Party: _____ Occupation: _____

Address: _____
Street City State/ Zip Code

(Work): _____ Ext: _____ Hours: _____ May we call you at work? Y N Driver's License #:_____

Dental Insurance Information (Primary)

Policyholder: _____ Relationship to Patient_____
Last First

Insurance Plan Name and Address: _____

Policy Holder's Birth Date: _____ SS #: _____ Group#:_____

Policy Holder's Address: _____
Street City State/Zip Code

Policy Holder's Employer Name: _____

Address: _____
Street City State/Zip Code

Is the Patient a full-time college student? If yes, name of college? _____

Is Patient insured under an additional policy? Yes No

Dental Insurance Information (Secondary)

Policyholder: _____ Relationship to Patient_____
Last First

Insurance Plan Name and Address: _____

Policy Holder's Birth Date: _____ SS #: _____ Group #:_____

Policy Holder's Address: _____
Street City State/Zip Code

Policy Holder's Employer Name: _____

Address: _____
Street City State/Zip

How did you learn about our practice?

☐ ***Designs in Dentistry*** patient (name):_____ ☐ ***Designs in Dentistry*** web site ☐ Location
☐ Newspaper/Magazine _____ ☐ Insurance company list /website ☐ Other_____

Payment for Services & Notice of Privacy Practices

Payment for dental services is due and payable at the time of treatment. A written financial estimate will be prepared prior to treatment. If you have dental insurance, as a courtesy, we will prepare and submit your dental claims. The patient/responsible party listed above is responsible for all charges, regardless of insurance coverage. I acknowledge receipt of Notice of Privacy Practices.

_____ Date: _____
Signature of patient, responsible party or guardian Relationship to Patient:

PLEASE BRING PHOTO ID